

offered by each profession and agency. The integration of these roles is the key to a community having a well-coordinated child fatality review system.

## VI. The Role of Committee Members

### Chairperson Roles and Responsibilities:

The District Attorney (or his/her designee) shall serve as the chairperson to preside over all child fatality review meetings. **The chairperson is not a separate member**; rather he or she is already a committee member and is designated by the committee to oversee data collection and to help organize/facilitate meetings.

When the chairperson of the CFR Committee receives a report from the coroner or the medical examiner regarding the death of a child, that chairperson shall review the report and findings as follows:

If the report indicates the child's death does not meet the criteria for review and the chairperson agrees with the decision, he or she should sign the form designated by the Panel (Form 1) stating the death does not meet criteria for review. The chairperson shall forward the form and findings to the Panel within **seven days** of receipt. If the chairperson believes that the death of a child meets the criteria for review, he or she should convene the committee within **30 days** of receipt of the report. Other responsibilities are as follows:

- Accept report and notification from the medical examiner or coroner about the death of a child
- Make a determination from the available resources, and according to established criteria, of the cases to be reviewed by the committee
- Distribute the list of cases to be reviewed to the committee members
- Arrange to have the necessary information from investigative reports, medical records, autopsy reports or other items made available to members of the committee
- Schedule and notify the committee members of upcoming review meetings
- Chair the committee meetings
- Oversee overall adherence to the child fatality review process

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- Oversee overall adherence to the child fatality review process
- Ensure that all reporting and data collection requirements are met including reports being forwarded to the District Attorney and the Panel
- Serve as liaison with each local agency, with other Child Fatality Review Committees, and with the Georgia Child Fatality Review Panel

### **Medical Examiner/Coroner Role and Responsibilities:**

If the death of a child occurs within the county of residence, the local medical examiner or coroner will notify the chairperson of the local CFR Committee within **48 hours** of the child's death. If the death occurs outside the child's county of residence, the attending coroner or medical examiner will notify the chairperson and coroner or medical examiner in that child's county of residence within **48 hours** of the child's death. (O.C.G.A. 19-15-3)

The medical examiner or coroner shall review the findings regarding the cause and manner of death for each child death report that he or she receives in the following manner:

If cause of death meets the criteria for review (pursuant Code Section 19-15-3[e]), the medical examiner or coroner shall complete and sign the form designated by the Panel (Form1) stating the death met the criteria for review. He or she shall forward the form findings, within **seven days** of the child's death, to the chairperson of the CFR Committee in the county or circuit of the child's residence. If cause of death does not meet the criteria for review the medical examiner or coroner shall complete and sign the form stating that the death did not meet the criteria for review and forward the form findings, within **seven days** of the child's death, to the chairperson of the CFR Committee in the county or circuit of the child's residence. Other responsibilities are as follows:

- Provide pertinent health and medical information regarding a child whose death is being reviewed by the CFR Committee
- Provide forensic information and analysis, including autopsy reports
- Participate in identifying risk factors to child safety and strategies to address these

- If a child is not a resident of the county in which he or she died, the coroner or medical examiner shall forward all information and all reports to coroner or medical examiner and CFR Committee chairperson in the county or circuit of the child's residence within the specified time frames
- Act as liaison with counterparts across the state

**District Attorney Role and Responsibilities:**

- Act as chairperson or designate a chairperson for the CFR committee.
- Explain criteria for pursuing a criminal or civil case, and keep committee informed about any actions taken in connection with a child's death
- Identify previous criminal or civil filings involving the child, family members or others involved with a child's death
- Provide victim assistance
- Participate in identifying risk factors to child safety and strategies to address these
- Act as liaison with counterparts across the state

**Department of Family and Children Services (DFCS) Roles and Responsibilities:**

- Conduct case investigations and intervention as appropriate
- Identify previous contacts of the child and family with DFCS
- Provide services to surviving siblings and family members at risk
- Develop intervention and public awareness programs to protect children at risk
- Make placement decisions
- Acts as liaison with counterparts in Georgia and other states

**Juvenile Court Roles and Responsibilities:**

- Identify previous contacts of the child and family with the Juvenile Court and/or Department of Juvenile Justice
- Make placement decisions; order follow-up services and case management to surviving siblings referred by DFCS
- Participate in identifying risk factors to child safety and strategies to address these risk factors
- Act as liaison with counterparts across the state

**Public Health Roles and Responsibilities:**

- Identify previous contacts of the child and family with the health department.

- Provide epidemiological, morbidity and mortality data to assist in the evaluation
- Promote intervention and public awareness programs to protect families and children at risk
- Act as liaison to counterparts across the state

**Mental Health Roles and Responsibilities:**

- Provide information about any services sought or received by the child or family prior to the death
- Assist in the discovery and review of the child’s mental health or substance abuse records from public and private providers
- Provide follow-up services to surviving family members
- Promote intervention and public awareness programs to protect families and children at risk
- Act as liaison with counterparts across the state

**Law Enforcement Roles and Responsibilities:**

The responsibilities of the officer at the scene include: interviewing, documenting, and taking photographs at the death scene. The officer also assists the coroner or medical examiner in determining the cause, manner and mode of death. Other responsibilities are as follows:

- Conduct primary case management of investigation when there is possible criminal action
- Provide information on criminal histories of the child and/or family and suspects in child fatality cases
- Provide investigation or criminal records of child and family (i.e. reports, scene photographs, etc.)
- Participate in identifying risk factors to child safety and strategies to address these
- Act as liaison with counterparts across the state

**Prevention Advocate Roles and Responsibilities:**

- Facilitate discussion on prevention for each and every child fatality your committee reviews.
- Track data on child fatalities for your county in order to help the committee define/ redefine prevention strategies.
- Educate committee members on proven prevention tactics.
- Compile information and use this information to assist the committee with making changes in policy and legislation.
- Serve as a liaison/ link between the committee and various community resources.